AMA QUEENSLAND

Supporting Queensland doctors, creating better health.

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Queensland Health primary maternity services guidelines

AMA Queensland thanks Queensland Health for the opportunity to comment on its primary maternity services guidelines. Feedback has been provided via tracked changes and comments on the Word version of the draft guideline and in summary comments set out below.

Preferencing of non-medical maternity models

Doctors, especially obstetricians and GP obstetricians, are dismayed by the perpetuation of anti-medical and anti-doctor sentiment in broader public discourse about maternity care. There is a wrongful and dangerous belief that obstetricians 'intervene' unnecessarily when they recommend best practice treatment. There is also a pervasive narrative that midwives are the only experts at 'physiological birth' which is insulting to all medical practitioners who specialise in maternity care.

The establishment of the Office of the Chief Midwife has fed into these mistruths and generated significant distrust among doctors. The status of a stand-alone office that engages with groups who are openly hostile towards obstetricians, GP obstetricians and hospital maternity care itself is particularly galling and alarming. AMA Queensland submits that Queensland Health review the activities and value of the Office of the Chief Midwife and carefully consider its detrimental impact on the willingness of medical practitioners to work in Queensland Health maternity units, especially in regional, rural and remote areas.

In addition, doctors urged Queensland Health to invest in a public education campaign to correct the betrayal of patients and clinicians by the promulgation of harmful ideologies that promote all patients as suitable for physiologic low risk home births. Such ideologies are causing conflict in maternity units when women present in an emergency and inevitably result in unnecessary complaints to the regulator with claims doctors 'denied the patient a natural birth'. Such a campaign must also involve media activities given the widespread harm these views are causing.

General comments on the guidelines

Obstetricians and GP obstetricians raised the need to state the distinct differences between an offsite midwifery birth centre or homebirth model practicing within a team structure of a larger maternity unit and the midwifery-led rural proposition in the guideline. They submitted that other states have clear guidelines on the former, integrated care model and were disappointed Queensland Health's guideline does not clearly articulate or acknowledge them.

Doctors also questioned the troubling exclusion of private practicing midwives from the guideline. This is a growing model in southeast Queensland that is presenting problems for public maternity units with demands for private admitting rights for midwives and worrying reports of poor patient outcomes. Doctors rightly submit that private midwives should be required to follow standard, best practice guidelines, especially where they are publicly funded.

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Doctors reject the guideline's premise that the closure of regional maternity services, like those in Biloela and Chinchilla, justifies opening midwife led units without close maternity service supports and a team structure. Many are frustrated that Queensland Health continues to ignore the reasons these services cannot attract or retain the GP or rural generalist obstetricians, anaesthetists and paediatricians needed to operate safe and effective maternity units.

AMA Queensland members applauded the investment in new staff accommodation in Biloela, however, urged that more incentives such as this were needed. To date, there has been little exploration of incentives to attract doctors to rural and regional services beyond financial payments, including alternative employment models (e.g. VMO, fee for service, group GP, sessional appointments, private admitting rights). Doctors urged Queensland Health to offer a range of contracts to attract doctors to regional and rural Queensland facilities.

The following statement from a rurally based GP obstetrician is provided as part of this submission due to its accurate and succinct articulation of the sentiment of many doctors, particularly those experienced in providing maternity services outside metropolitan centres:

> *As a rural GPO since the mid-1980s, I have seen the best and worst of midwifery led care.*
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> *The best is when it is embedded within a collaborative framework, where the midwives are supported, enabled and subject to peer feedback at M&Ms etc; where the mother can have a risk assessment and be provided with realistic expert advice by the obstetrician and midwife; where there isn't a turf war. Everyone is there to help the family, not to defend their little fiefdom.*
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> *The worst is when the midwife becomes the default provider, when it is perceived (by people who are ill-informed or ignorant) to be too tough or expensive to align training pathways, governance, quality and safety with best practice.*
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> *Midwife led models in isolation, hundreds of kilometres from anywhere, reliant on retrieval services that can and will be inconsistent (due to weather, time of day, asset availability) exposes rural communities to substantial risk. I have seen babies die by the side of the road. I have seen women nearly bleed out in a small rural unit and exceeded the speed limit to get there to repair the cervical tear, 200kms from where I live and work. The isolated midwife or doula and their patient are the loaded cannon of rural practice and some of the PTSD rural doctors experience revolves around the obstetric disasters that ensue, often experienced more than once in their working careers.*
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> *I support patient autonomy; I support the concept that home birth can be safe. I do not support anything but a collaborative well-supported solution that does not place two lives at risk, especially through a lack of resources, access to emergency care and which commits women to an inconsistent retrieval and mitigation strategy.*